SOUTH DAKOTA MEDICAID

PRIOR AUTHORIZATION MANUAL

South Dakota Department of Social Services

Division of Medical Services

DSS

Strong Families - South Dakota's Foundation and Our Future

2015

700 Governors Drive | Pierre, SD 57501

IMPORTANT CONTACT NUMBERS

<table>
<tr><td colspan="2">Telephone Service Unit for Claim Inquiries
In State Providers: 1-800-452-7691
Out of State Providers: (605) 945-5006</td></tr>
<tr><td colspan="2">Provider Response for Enrollment and Update Information
1-866-718-0084
Provider Enrollment Fax: (605) 773-8520</td></tr>
<tr><td colspan="2">Prior Authorizations
Pharmacy Prior Authorizations: 1-866-705-5391
Medical and Psychiatric Prior Authorizations: (605) 773-3495</td></tr>
<tr><td>Dental Claim and Eligibility Inquiries
1-800-627-3961</td><td>Recipient Premium Assistance
1-888-828-0059</td></tr>
<tr><td>Managed Care Updates
(605) 773-3495</td><td>SD Medicaid for Recipients
1-800-597-1603</td></tr>
<tr><td colspan="2">Medicare
1-800-633-4227</td></tr>
<tr><td colspan="2">Division of Medical Services
Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291
Division of Medical Services Fax: (605) 773-5246</td></tr>
<tr><td colspan="2">Medicaid Fraud</td></tr>
<tr><td>Welfare Fraud Hotline: 1-800-765-7867

File a Complaint Online:
http://atg.sd.gov/TheOffice/Divisions/MedicaidFraudControlUnit.aspx</td><td>OFFICE OF ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT
Assistant Attorney General Paul Cremer
1302 E Hwy 14, Suite 4
Pierre, South Dakota 57501-8504
PHONE: 605-773-4102
FAX: 605-773-6279
EMAIL:
ATGMedicaidFraudHelp@state.sd.us</td></tr>
<tr><td colspan="2">Join South Dakota Medicaid’s listserv to receive important updates and guidance from the Division of Medical Services:
http://www.dss.sd.gov/medicaid/contact/ListServ.aspx</td></tr>
</table>

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Strong Families - South Dakota's Foundation and Our Future

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INTRODUCTION

This manual is one of a series published for use by medical services providers enrolled in South Dakota Medicaid. It is designed to be readily updated by replacement or addition of individual pages as necessary. It is designed to be used as a guide in preparing claims, and is not intended to address all South Dakota Medicaid rules and regulations. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing South Dakota Medicaid in Article § 67:16.

Problems or questions regarding South Dakota Medicaid rules and policies as well as claims, covered services, and eligibility verification should be directed to:

Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Problems or questions concerning recipient eligibility requirements can be addressed by the local field Division of the Department of Social Services in your area or can be directed to:

Department of Social Services
Division of Economic Assistance
700 Governors Drive
Pierre, SD 57501-2291
PHONE: (605) 773-4678

Medicare is a separately administered federal program and questions concerning Medicare cannot be answered by South Dakota Medicaid Program personnel.

CHAPTER I:
GENERAL INFORMATION

The purpose of the Medicaid Program (Title XIX) is to assure the availability of quality medical care to low-income individuals and families through payments for a specified range of services. The Medicaid program was implemented in South Dakota in 1967.

Funding and control of Medicaid are shared by federal and state governments under Title XIX of the Social Security Act; regulations are written to comply with the actions of Congress and the State Legislature.

A brief description of general information about the Medicaid program is provided in this manual. For specific rule and regulation requirements, the provider is responsible to become familiar with the Administrative Rules of South Dakota (ARSD) governing Medicaid in Article § 67:16.

PROVIDER RESPONSIBILITY

ENROLLMENT AGREEMENT

Providers, who render one or more services covered under the Medicaid Program, and who wish to participate in the Medicaid Program, must become an enrolled provider. The provider must sign a Provider Agreement with the Department of Social Services. Providers must comply with the terms of participation, as identified in the agreement and requirements, stated in Administrative Rules of South Dakota (ARSD § 67:16) which govern the Medicaid Program. Failure to comply with these requirements may result in monetary recovery, or civil or criminal action.

An individual (i.e. consultant, staff, etc.) who does not have a provider agreement, but who furnishes a covered service to a recipient under your provider agreement and receives payment or benefits indirectly from the Department of Social Services, is also subject to the rules, regulations and requirements of the South Dakota Medicaid Program.

Participating providers agree to accept Medicaid payment as payment in full for covered services. The provider must NOT bill any of the remaining balance to the recipient, their family, friends or political subdivisions.

PROVIDER IDENTIFICATION NUMBER

A provider of health care services must have a ten (10) digit National Provider Identification (NPI) number.

TERMINATION AGREEMENT

When a provider agreement has been terminated, the Department of Social Services will not pay for services provided after the termination date. Pursuant to ARSD § 67:16:33:04, a provider agreement may be terminated for any of the following reasons:

- The agreement expires;
- The provider fails to comply with conditions of the signed provider agreement or conditions of participation;
- The ownership, assets, or control of the provider's entity are sold or transferred;
- Thirty days elapse since the department requested the provider to sign a new provider agreement;
- The provider requests termination of the agreement;
- Thirty days elapse since the department provided written notice to the provider of its intent to terminate the agreement;
- The provider is convicted of a criminal offense that involves fraud in any state or federal medical assistance program;
- The provider is suspended or terminated from participating in Medicare;
- The provider's license or certification is suspended or revoked; or
- The provider fails to comply with the requirements and limits of this article.

OWNERSHIP CHANGE

A participating provider who sells or transfers ownership or control of the entity must give the Department of Social Services written notice of the pending sale or transfer at least 30 days before the effective date. In a change of ownership, the seller is responsible for maintaining and ensuring access to records generated prior to the sale. This responsibility may be transferred to the buyer through a sales contract or written agreement. The South Dakota Medicaid provider number is NOT transferable to the new owner. The new owner must apply and sign a new provider agreement and a new number must be issued before claims can be submitted.

LICENSING CHANGE

A participating provider must give the Department of Social Services written notice of any change in the provider's licensing or certification status within ten days after the provider receives notification of the change in status.

RECORDS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records

must be retained for at least six (6) years after the last date a claim was paid or denied. Records must not be destroyed when an audit or investigation is pending.

Providers must grant access to these records to agencies involved in Medicaid review or investigations.

THIRD PARTY LIABILITY

SOURCES

Third-party liability is the payment source or obligation, other than Medicaid, for either partial or full payment of the medical cost of injury, disease, or disability. Payment sources include Medicare, private health insurance, worker's compensation, disability insurance, and automobile insurance.

PROVIDER PURSUIT

Because South Dakota Medicaid is the payer of last resort, the provider must pursue the availability of third-party payment sources.

CLAIM SUBMISSIONTO THIRD-PARTY SOURCE

The provider must submit the claim to a third-party liability source before submitting it to Medicaid except in the following situations:

- Prenatal care for a pregnant woman;
- HCBS waiver services;
- Services for early and periodic screening, diagnosis, and treatment provided under ARSD § 67:16:11, except for psychiatric inpatient services, nutritional therapy, nutritional supplements, and electrolyte replacements;
- A service provided to an individual if the third-party liability is derived from an absent parent whose obligation to pay support is being enforced by the department;
- The probable existence of third-party liability cannot be established at the time the claim is filed;
- The claim is for nursing facility services reimbursed under the provisions of ARSD § 67:16:04; or
- The claim is for services provided by a school district under the provisions of ARSD § 67:16:37.

A claim submitted to Medicaid must have the third-party explanation of benefits (EOB) attached, when applicable.

PAYMENTS

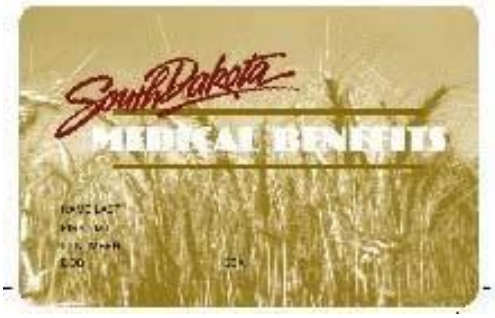
When third-party liability has been established and the amount of the third-party payment equals or exceeds the amount allowed under Medicaid, the provider must not seek payment from the recipient, relative, or any legal representative.

The provider is eligible to receive the recipient's third party liability responsibility amount or the amount allowed under the department's payment schedule less the third-party liability amount, whichever is less.

When third-party liability source(s) and Medicaid have paid for the same service the provider must reimburse Medicaid. Reimbursement must be either the amount paid by the third party source(s) or the amount paid by Medicaid, whichever is less.

RECIPIENT ELIGIBILITY

The South Dakota Medicaid Identification Card is issued by the Department of Social Services on behalf of eligible South Dakota Medicaid recipients. The magnetic stripe card has the same background as the Supplemental Nutrition Assistance Program (SNAP) EBT card. The information on the face of the card includes the recipient's complete name (first, middle initial and last), the nine digit recipient identification number (RID#) plus a three digit generation number, and the recipient's date of birth and sex.



NOTE: The three digit generation number is automatically added in the system to indicate the number of cards sent to an individual. This number is not part of the recipient's ID number and should not be entered on a claim.

Each card has only the name of an individual on it. There are no family cards.

Recipients must present a South Dakota Medicaid identification card to a South Dakota Medicaid provider each time before obtaining a South Dakota Medicaid covered service. Failure to present their South Dakota Medicaid identification card is cause for payment

denial. Payment for noncovered services is the responsibility of the recipient, as stated in ARSD §67:16:01:07.

South Dakota Medicaid emphasizes both the recipient's responsibility to present their ID card and the provider's responsibility to see the ID card each time a recipient obtains services. It is to the provider's advantage to see the ID card to verify that the recipient is South Dakota Medicaid eligible at the time of service, as well as to identify any other program limitations and the correct listing of the recipient name on the South Dakota Medicaid file.

The Medicaid Eligibility Verification System (MEVS) offers three ways for a provider to access the state's recipient eligibility file:

- **Point of Sale Device:** Through the magnetic strip, the provider can swipe the card and have an accurate return of eligibility information in approximately 10 seconds.
- **PC Software:** The provider can key enter the RID# into PC software and in about 10 seconds have an accurate return of eligibility information.
- Secure Web Based Site.

All three options provide prompt response times and printable receipts, and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through Emdeon.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete. This system is limited to current eligibility verification only.

For more information about the MEVS system, contact Emdeon at 1-866-369-8805 for new customers and 1-877-469-3263 for existing customers or visit Emdeon's website at www.emdeon.com.

MEVS ELIGIBILITY INFORMATION

Through the MEVS (card swipe or PC entry) the provider receives a paper or electronic receipt ticket, immediately upon eligibility verification (approximately 10 seconds). The following is an example of the "ticket' sent to the provider.

Please note that certain South Dakota Medicaid recipients are restricted to specific limits on covered services. It is very important that you check for restrictions.

**********SD MEDICAID**********
Eligibility 10/19/2004 08:47:25
**********PAYER INFORMATION**********
Payer: SOUTH DAKOTA MEDICAL SERVICES
Payer ID: SD48MED
**********PROVIDER INFORMATION**********
Provider: Dr. Physician
Service Provider #: 9999999
**********SUBSCRIBER INFORMATION**********
Current Trace Number: 200406219999999
Assigning Entity: 9000000000
Insured or subscriber: Doe, Jane P.
Member ID: 999999999
Address: Pierre Living Center
2900 N HWY 290
PIERRE, SD 575011019
Date of Birth: 01/01/1911
Gender: Female
**********ELIGIBILITY AND BENEFIT INFORMATION**********
**********HEALTH BENEFIT PLAN COVERAGE**********
ACTIVE COVERAGE
Insurance Type: Medicaid 13
Eligibility Begin Date: 10/19/2004
ACTIVE COVERAGE
Insurance Type: Medicare Primary 13
Eligibility Date Range: 10/19/2004 – 10/19/2004

**********HEALTH BENEFIT PLAN COVERAGE**********
**********OTHER OR ADDITIONAL PAYER**********
Insurance Type: Other
Benefit Coord. Date Range: 10/19/2004-10/19/2004
Payer: BLUE CROSS/BLUE SHIELD
Address: 1601 MADISON
PO BOX 5023
SIOUX FALLS, SD 571115023
Information Contact: Telephone: (800)774-1255
TRANS REF #: 999999999

Over 150 payers now support eligibility requests. For a full list, contact fax-on-demand at 800-7602804, #536. To add new payers, call 800-215-4730.

CLAIM STIPULATIONS

PAPER CLAIMS

Claims that, by policy, require attachments and reconsideration claims will be processed for payment on paper.

ELECTRONIC CLAIM FILING

Electronic claims must be submitted using the 837I, HIPAA-compliant X12 format.

SUBMISSION

The provider must verify an individual's eligibility before submitting a claim, either through the ID card or, in the case of long-term care, a letter from the caseworker. The provider must record the recipient identification information as required for the claim.

A provider may only submit claims for those items and services that the provider knows or should have known are covered under South Dakota Medicaid. A provider must not submit a claim for items or services that have not been completed or have not actually been provided. A provider can be reimbursed only for medically necessary covered services actually provided to South Dakota Medicaid recipients eligible on the date the service is provided.

TIME LIMITS

The department must receive a provider's completed claim form within 6 months following the month the services were provided, as stated in ARSD § 67:16:35:04. This time limit may be waived or extended only when one or more of the following situations exist:

- The claim is an adjustment or void of a previously paid claim and is received within 3 months after the previously paid claim;
- The claim is received within 6 months after a retroactive initial eligibility determination was made as a result of an appeal;
- The claim is received within 3 months after a previously denied claim;
- The claim is received within 6 months after the provider receives payment from Medicare or private health insurance or receives a notice of denial from Medicare or private health insurance; or
- To correct an error made by the department.

PROCESSING

The Division of Medical Services processes claims submitted by providers for their services as follows:

- Claims and attachments are received by the Division of Medical Services and sorted by claim type and microfilmed.
- Each claim is assigned a unique fourteen (14) digit Reference Number. This number is used to enter, control and process the claim. An example of a reference number is 2004005-0011480. The first four digits represent the year. The next 3-digits represent the day of the year the claim was received. The next 7-digits are the sequential number order of the claims received on that day. Each line is separately adjudicated, reviewed and processed using the 14-digit reference number. However, claims with multiple lines will be assigned a single claim reference number; and
- Each claim is individually entered into the computer system and is completely detailed on the Remittance Advice.

To determine the status of a claim, providers must reconcile the information on the Remittance Advice with their files.

UTILIZATION REVIEW

The Federal Government requires states to verify receipt of services. Each month a sample of South Dakota Medicaid recipients are sent a survey letter requesting verification of services paid the previous month on their behalf. Such services are identified in non-technical terms, and confidential services are omitted. Although the directions are as clear as possible, providers should be prepared to assure any inquiring recipients that this letter is not a bill.

Under 42 C.F.R. part 456, South Dakota Medicaid is mandated to establish and maintain a Surveillance and Utilization Review System (SURS). The SURS unit safeguards against unnecessary or inappropriate use of South Dakota Medicaid services or excess payments, assesses the quality of those services and conducts a post-payment review process to monitor both the use of health services by recipients and the delivery of health services by providers under 42 CFR 456.23.

Overpayments to providers may be recovered by the SURS unit, regardless of whether the payment error was caused by the provider or by South Dakota Medicaid.

FRAUD AND ABUSE

The SURS Unit is responsible for the identification of possible fraud and/or abuse. The South Dakota Medicaid Fraud Control Unit (MFCU), under the Office of the Attorney General, is certified by the Federal Government with the primary purpose to detect, investigate, and prosecute any fraudulent practices or abuse against the Medicaid Program. Civil or criminal action or suspension from participation in the Medicaid program is authorized under South Dakota Codified Law (SDCL) 22-45 entitled, Unlawfully Obtaining Benefits or Payments from the Medical Assistance Program. It is the provider's responsibility to become familiar with all sections of SDCL 22-45 and ARSD § 67:16.

DISCRIMINATION PROHIBITED

South Dakota Medicaid, participating medical providers, and contractors may not discriminate against South Dakota Medicaid recipients on the basis of race, color, creed, religion, sex, ancestry, handicap, political belief, marital or economic status, or national origin. All enrolled South Dakota Medicaid providers must comply with this non-discrimination policy. A statement of compliance with the Civil Rights Act of 1964 shall be submitted to the Department upon request.

MEDICALLY NECESSARY

South Dakota Medicaid covered services are to be payable under the Medicaid Program when the service is determined medically necessary by the provider. To be medically necessary, the covered service must meet all of the following conditions under ARSD §67:16:01:06.02:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service that is more conservative or substantially less costly.

CHAPTER II: SERVICES REQUIRING PRIOR AUTHORIZATION

Listed below are services requiring prior authorization. Each link provides service requirements, forms, and contact information to submit requests for prior authorization.

OUT-OF-STATE SERVICES

- Inpatient and Outpatient Services

DURABLE MEDICAL EQUIPMENT

- Bone Growth Stimulators
- Continuous Glucose Monitoring Policy
- Continuous Passive Motion Devices
- Cough Stimulating Devices
- Cranial Remolding Helmets
- Gait Trainers
- High-Frequency Chest Wall Oscillation Device
- Low Air Loss Mattress / Pressure Reduction Therapy
- Lymphedema pumps
- EPSDT: Non-Covered Items Under Age 21
- Speech Generating Devices / Augmentative Communication Devices
- Wound Vacs

HOME HEALTH

- Extended Home Health Services / Private Duty Nursing

INPATIENT HOSPITALIZATION

- Long Term Acute Care
- Medically Complex / Rehab Under Age 21
- Neonatal Intensive Care Units
- Psychiatric Residential Treatment Facilities
- Psychiatric Units
- Rehabilitation Units

NUTRITION

- Enteral Nutrition for Adults Over Age 21
- EPSDT: Special Nutrition Under Age 21
- Parenteral Nutrition

OTHER OUTPATIENT SERVICES

- Botox
- Hydroxyprogesterone Caproate (Makena)
- Hyperbaric Oxygen Treatment
- Mental Health Visits Under Age 2
- Mental Health Visits Over Coverage Limit
- Non-Covered Services Under Age 21 EPSDT (Vision, audiology, etc.)
- Synagis

SURGICAL PROCEDURES

- Bariatric
- Breast Reconstruction
- Breast Reduction
- Cochlear implants
- Nerve stimulators
- Panniculectomy
- Questionably Cosmetic
- Removal of Excess Skin
- Spinal
- Transplants

OTHER PROCEDURES

These procedures do not require prior authorization, but have specific requirements including a specialized form.

- Hysterectomy
- Sterilization

CHAPTER III: PRIOR AUTHORIZATION REQUEST SERVICES AND FORMS

BARIATRIC SURGERY

Gastric surgery for weight loss is covered when it is an integral and necessary part of a course of treatment for another illness such as cardiac disease, respiratory disease, diabetes, or hypertension and the individual meets all of the following criteria:

1. The individual is severely obese with Body Mass Index (BMI) over 40 and is at least 21 years of age.
    - BMI = weight in kilograms (2.2 lbs/kg) divided by the square of height in meters (39.37 in./meter);
2. There is a significant interference with activities of daily living.
3. There is documented conservative (non-surgical) promotion of weight loss by a physician supervised weight loss program. Dietician consult is recommended, if available, and the individual must have documentation of 4 consecutive monthly visits with their primary care physician to monitor compliance with, and results of, a conservative weight loss program.
4. The recipient is motivated and well-informed. The recipient is free of significant systemic illness unrelated to obesity, is not actively abusing drugs or alcohol, and does not use tobacco or if a tobacco user has discontinued use for 4 months documented in the medical record.
5. It is medically and psychologically appropriate for the individual to have such surgery.
6. At least one of the following must also be present:
    - History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine as documented by physical examination; or
    - Hypertension requiring medical therapy; or
    - Congestive heart failure manifested by laboratory evidence or past evidence of vascular congestion such as hepatomegaly, peripheral edema, or pulmonary edema; or
    - Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or
    - Respiratory insufficiency or hypoxemia at rest; or
    - Type II diabetes not adequately controlled by compliance with medical treatment; or
    - Sleep apnea of at least moderate severity, documented by appropriate testing.

7. The procedure will be performed at a Medicare approved Center of Excellence in South Dakota and if lap band/gastric banding procedure has been approved by the South Dakota Medical Assistance Program the follow-up adjustments must be performed by the surgeon who did the original surgery or a surgical partner in that practice.

67:16:01:06.02. Covered services must be medically necessary. Services covered under this article must be medically necessary. To be medically necessary, the covered service must meet the following conditions:

1. It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
2. It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
3. It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
4. It is not furnished primarily for the convenience of the recipient or the provider; and
5. There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical Documentation to support medical necessity which includes all co morbidities (history and physicals, discharge summaries, progress notes, specialty physician consults, etc.)
- Current psychological/psychiatric evaluation addressing appropriateness for potential bariatric surgery. These evaluations need to be completed by a psychologist, psychiatrist, CSW PIP, LPC-MH, or CNP-MH.
- Documentation which supports failure of conservative weight loss efforts for the past year managed by a physician (PCP). Please include all available documentation regarding weight loss attempts such as the dictation from a dietitian if one has been seen, clinic progress notes, food and exercise logs, etc.
- Current height, weight, and BMI
- Surgical Consultation, including documentation for choice of surgical procedure and why.

Please note: Individuals with Medicare must seek a coverage determination from Medicare. Medicaid's coverage will be dependent on Medicare's determination.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

ADDITIONAL RESOURCES

National Institutes of Health Obesity

- Body Mass Index Table

BONE GROWTH STIMULATORS

Non-invasive (ultrasonic or electrical) bone growth stimulators may be covered by South Dakota Medicaid for skeletally mature individuals if one of the following conditions are met and written prior authorization has been obtained. The nonunion cannot be related or due to malignancy.

1. There is a nonunion of a long bone fracture and the fracture gap is less than or equal to 1 cm and it is greater than 90 days from the date of injury or initial treatment and cessation of healing is documented by 2 sets of radiographs with multiple views least 90 days apart;
2. There is a failed fusion of a joint other than spine and a minimum of nine months has elapsed since the last surgery;
3. There is congenital pseudarthrosis;
4. Closed fractures when there is suspected high risk for delayed fracture healing or nonunion as a result of either of the following:
    - due to location of fracture and poor blood supply (e.g. scaphoid, 5th metatarsal) or
    - presence of comorbidities likely to compromise healing (e.g. smoking, diabetes, renal disease, or other metabolic disease); or
5. It is an adjunct to spinal fusion surgery for patients at high risk of pseudarthrosis due to a previously failed spinal fusion at the same site or for those undergoing multiple level fusions. For purposes of this authorization a multiple level fusion involves three or more vertebrae, for example: L2-L4, L3-L5, or L4-S1.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- All applicable medical records to support requirements.
    - These must include the appropriate x-ray reports and interpretations.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

BOTOX

The Prior Authorization Request Form must be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

BREAST RECONSTRUCTION

Breast reconstruction surgery is covered if the surgery is needed because of a medically necessary mastectomy.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Surgical Evaluation and applicable medical records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

BREAST REDUCTION

South Dakota Medicaid must prior authorize surgery to reduce the size of the breast. The authorization is based on documentation submitted to South Dakota Medicaid by the physician performing the procedure.

The documentation must substantiate the existence of the following conditions:

- The individual must be at least 21 years of age and have reached physical maturity.
- If the individual has a BMI of more than 35 there must be documentation of participation in a physician supervised weight loss program over 6 months without any change in the size of the breasts.
- If the individual is age 40 or older must have had a normal mammogram within the last 2 years, or if age 35 to 40 and has a first degree relative with breast cancer must have had one normal mammogram.
- The individual has not given birth in the last 6 months.
- The individual suffers from severe back or neck pain resulting in interference with activities of daily living and not responsive to documented conservative treatment after 3 months; or the individual suffers from nerve root compression symptoms of ulnar pain or paresthesias not responsive to documented conservative treatment after 3 months.
- The individual has intertrigo not responsive to documented medical treatment after 3 months.
- The amount of tissue to be removed in grams must be equal or greater to the criteria in the chart below (calculated by the Gehan/George formula).

BODY SURFACE AREA (m2)	AMOUNT OF TISSUE TO BE REMOVED FROM EACH BREAST
1.35	199
1.40	218
1.45	238
1.50	260
1.55	284
1.60	310
1.65	338
1.70	370

BODY SURFACE AREA (m2)	AMOUNT OF TISSUE TO BE REMOVED FROM EACH BREAST
1.75	404
1.80	441
1.85	482
1.90	527
2.00	628
2.05	687
2.10	750
2.15	819
2.20	895
2.25	978
2.30	1068
2.35	1167
2.40	1275
2.45	1393
2.50	1522
2.55	1662

The surgeon must submit photographic documentation confirming severe macromastia. A complete history and physical, including height and weight must be submitted with the prior authorization request. An estimate of amount of tissue (in grams) to be removed from each breast should be submitted with the request for prior authorization and a copy of the operative report with documentation of tissue removed must be submitted with the claim form.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental

disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;

- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Surgical Consultation and applicable medical records. Documentation must include the following:
  - Current actual height and weight;
  - Clinical evaluation of the signs or symptoms have been present for at least 6 months;
  - Non-surgical interventions as appropriate;
  - Determining that dermatologic signs and/or symptoms are refractory to, or recurrent following, a completed course of medical management;
  - Legible and thorough examination of findings;
  - Estimated amount of tissue to be removed;
  - Pictures with multiple views;
  - Other options for treatment in addition to surgical management; and
  - Measurement of ptosis

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

CARE MANAGEMENT FOR REHABILITATION UNITS

Care Management regulations are found in ARSD Chapter 67:16:40. Care Managers prior authorize in-state and out-of-state rehabilitation services.

ADMISSION REQUIREMENTS

An individual's admission to a rehabilitation unit is a covered service if the hospital received authorization for the admission under § 67:16:40:04 and the care manager determines that the following criteria are met:

1. The individual's previous medical condition was functional;
2. The individual is capable of weekly improvement in the activities of daily living;
3. The individual's primary medical condition is stable; and
4. The individual is able to participate in rehabilitation therapies and can demonstrate gains in functional abilities.

REQUIREMENTS FOR CONTINUED STAY

An individual's continued stay in a rehabilitation unit is a covered service under this chapter if the individual demonstrates weekly improvement in becoming independent in the activities of daily living and is complying with the recommendations made through the care conference.

CRITERIA FOR TERMINATING COVERAGE

An individual's care in a rehabilitation unit becomes a non-covered service if the care manager determines that the individual meets any of the following criteria:

1. The individual has reached potential in the current setting;
2. The individual is functional;
3. The individual's condition is stable to the point of receiving outpatient care or care in an alternative setting; or
4. The individual is not complying with the recommendations made through the care conference.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

CARE MANAGEMENT PSYCHIATRIC UNITS

Care Management regulations are found in ARSD Chapter 67:16:40. Care Managers prior authorize out-of-state psychiatric services. In-state in-patient hospital psychiatric services are prior authorized by the South Dakota Foundation for Medical Care.

An individual's psychiatric care is a covered service under this chapter if the hospital received authorization for the admission under ARSD §67:16:40:04 and the following conditions are met:

1. A physician completed a medical assessment of the individual and had at least a telephone consultation with a psychiatrist. The psychiatric consultation or diagnosis must include a treatable mental health condition. An admission is not allowed on the basis of a previous diagnosis if symptoms associated with the diagnosis are not active at the time of the admission;
2. Outpatient services have failed or are not available in the community, or available services do not meet the treatment needs of the individual;
3. Treatment of the individual's psychiatric condition requires services on an inpatient basis under the direction of a physician, and there is an expectation that the individual will improve with psychiatric treatment of less than ten days;
4. Inpatient services are expected to improve the individual's condition or prevent further regression so that the inpatient services will no longer be needed; and
5. The individual meets one of the following criteria:
    a. Exhibits behavior which supports a reasonable expectation that the individual will inflict serious physical injury upon himself or others in the very near future, including a recently expressed threat which, if considered in light of its context or in light of the individual's recent previous acts, is substantially supportive of an expectation that the threat will be carried out;
    b. Exhibits psychotic behavior with hallucinations or delusions;
    c. Is admitted under the provisions of SDCL 27A-10-1 and 27A-10-2 for a 24-hour hold for an evaluation; or
    d. Experiences reactions or intolerances to medications which cannot be managed in an outpatient or medical floor setting.

Within 24 hours after an individual is admitted for inpatient psychiatric care, the hospital must have a psychiatrist complete a psychiatric evaluation of the individual. The evaluation must be included in the individual's medical record.

An individual's continuous and uninterrupted stay in inpatient psychiatric care is a covered service if the care manager determines that the following criteria are met:

1. The individual continues to be a danger to self or others and is not able to function or utilize outpatient care, as reflected in the physician's, nurse's, or auxiliary staff's notes;
2. The individual is complying with the recommendations made through the care conferences; and
3. The individual's daily progress notes show improvement towards the goal of discharge.

An individual's psychiatric care becomes a non-covered service when the care manager determines that the conditions of ARSD §67:16:40:07 are no longer met.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Out-of-State Prior Authorization Request Form

Submit completed documentation to:

Out-of-State Psychiatric Services
Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

In-State Inpatient Hospital Psychiatric Services
South Dakota Foundation for Medical Care
2600 West 49th Street
Sioux Falls, SD 57105
Fax: 605-773-0580
Phone: 605-336-3505

COCHLEAR IMPLANT

A cochlear implant requires prior authorization. Authorization is based on written documentation submitted to the department by the physician that confirms the following:

1. The implant will provide an awareness and identification of sound and will facilitate communication;
2. There is a diagnosis of sensorineural hearing loss that is not clinically improved by the use of a hearing aid;
3. The individual has a cochlea that will accept an implant;
4. There are no lesions of the individual's auditory nerve or acoustic areas of the central nervous system; and
5. The individual demonstrates the cognitive ability to use auditory clues and there is a willingness to undergo an extended program of rehabilitation.

Services, supplies, and implant systems are not covered if the request is to replace or upgrade a device that is functioning appropriately.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

CONTINUOUS GLUCOSE MONITORING POLICY

South Dakota Medicaid will not cover continuous glucose monitoring systems for individual recipients.

With Prior Authorization, South Dakota Medicaid may provide continuous glucose monitoring under the following circumstances:

1. If continuous glucose monitoring is provided by the recipient's endocrinologist, South Dakota Medicaid will reimburse the cost of monitoring for a continuous 72 hour period 2 times per year through the endocrinologist's office;
2. If a recipient already owns the continuous glucose monitoring system, South Dakota Medicaid will provide coverage for one box of 4 sensors every 6 months.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- All applicable medical records to support requirements in ARSD.
    - These must include the appropriate x-ray reports and interpretations.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

CONTINUOUS PASSIVE MOTION DEVICES

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Physician's prescription
- Applicable medical records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

COUGH STIMULATING DEVICES

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Medical records including:
  - Physician's prescription;
  - Any previous hospitalizations for respiratory illness;
  - All previous therapies tried; or
    E.G. chest percussion and postural drainage, intermittent positive pressure breathing (IPPB), incentive spirometry, inhalers, positive expiratory pressure (PEP) mask therapy, or flutter devices
  - Documentation supporting why other more conservative treatments have not been attempted.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

CRANIAL REMOLDING ORTHOSIS

All requests for Cranial Remolding Orthosis (CRO) must be medically necessary and require prior authorization. Coverage will be determined by the following:

- Diagnosis must be consistent with the recipient's symptoms and condition and be rated as moderate to severe. If scans are submitted, interpretation of the results must be included in narrative form. Severity assessment forms are helpful (an example would be the documents produced by Cranial Technologies Inc. 2002 Rev 01).
- Documentation of the initial evaluation and course of treatment with progress included.
- Documentation of a 2 month trial of repositioning. If a 2 month trial of repositioning is not done, thorough documentation explaining why.
- Documentation of how other existing conditions (torticollis, complications at birth, prematurity, etc.) affect the condition and treatment.
- Documentation that justifies why a custom molded helmet is the most effective course of treatment and that there is no other equally effective course of therapy that is more conservative or substantially less costly, such as a prefabricated helmet.

DOCUMENTATION REQUIREMENTS

- Prescription
- Medical Records – including diagnosis, history of treatment, assessment of severity and any other documentation supporting the request.
- DME and Nutrition Prior Authorization Request Form

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

EPSDT

SPECIAL NUTRITION, DME, OR OTHER NON-COVERED SERVICES FOR CHILDREN UNDER 21 YEARS OLD

Any service for a child that is medically necessary but falls outside coverage limits requires prior authorization by the Department of Social Services.

DOCUMENTATION REQUIREMENTS

Please submit the general prior authorization form, prescription and any other documentation that supports the request. Other documentation may include but is not limited to lab or test results, treatment history, letters from providers, medical evaluations, and other medical records.

- General Prior Authorization Request Form

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: EPSDT Coordinator
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

GAIT TRAINERS

Gait Trainers are a covered service for children 20 years of age and younger when a prior authorization has been obtained.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Medical records including:
  - Physician's prescription;
  - Evaluation for the device
  - Therapy records (PT and OT)
  - Estimated amount of time per day they intend to use the device
  - Other durable medical devices that the child uses or anticipates using (e.g. Stander, power wheel chair, etc.)

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

HIGH-FREQUENCY CHEST WALL OSCILLATION DEVICES

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Medical records including:
  - Physician's prescription;
  - Any previous hospitalizations for respiratory illness;
  - Documentation of failure of standard treatments to adequately mobilize retained secretions; or
  - Documentation supporting why other more conservative treatments have not been attempted.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

HYDROXYPROGESTERONE CAPROATE (MAKENA®)

Makena® is FDA approved to reduce the risk of preterm birth in women with a singleton pregnancy who have a history of singleton spontaneous preterm birth. Makena® is not intended for use in women with multiple gestations or other risk factors for preterm birth.[1]

Makena® requires prior authorization. Since Makena cannot be administered by the patient it is classified as physician administered. Physician administered drugs are not covered through the Medicaid pharmacy benefit and cannot be billed by pharmacies; these agents must be billed by the prescribing physician or their facility.

APPROVAL CRITERIA

Approval will be granted for treatment beginning between weeks 16 and 20 of gestation and continuing until week 37 of gestation or delivery, whichever occurs first.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- All applicable medical records to support requirements.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

[1] Recipient has a history of singleton spontaneous preterm birth and is currently pregnant with a singleton.

HYPERBARIC OXYGEN THERAPY

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients. This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

REQUIREMENTS FOR HYPERBARIC OXYGEN THERAPY

Hyperbaric oxygen therapy is a modality in which the entire body is placed in a chamber and exposed to oxygen under increased atmospheric pressure. The department must authorize hyperbaric oxygen therapy before it is provided. Hyperbaric oxygen therapy is limited to outpatient treatment for treatment of the following:

1. Acute carbon monoxide intoxication;
2. Decompression illness;
3. Gas embolism;
4. Gas gangrene;
5. Acute traumatic peripheral ischemia. Adjunctive treatment must be used in combination with accepted standard therapeutic measures when loss of function, limb, or life is threatened;
6. Crush injuries and suturing of severed limbs. Adjunctive treatment must be used when loss of function, limb, or life is threatened;
7. Meleney ulcers. Any other type of cutaneous ulcer is not covered;
8. Acute peripheral arterial insufficiency;
9. Preparation and preservation of compromised skin grafts;

10. Chronic refractory osteomyelitis which is unresponsive to conventional medical and surgical management;
11. Osteroradionecrosis as an adjunct to conventional treatment;
12. Soft tissue radionecrosis as an adjunct to conventional treatment;
13. Cyanide poisoning;
14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; or
15. Diabetic wounds of the lower extremities if the requirements of § 67:16:02:05.13 are met.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical record documentation to meet the above requirements

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

HYSTERECTOMY

The federal regulation for hysterectomy requires that the recipient has been informed that the hysterectomy will render the individual permanently incapable of reproducing.

The recipient must sign a statement acknowledging receipt of infertility information prior to surgery. Most hospital operative permits do not meet the federal requirements for hysterectomy information. The Acknowledgment of Information for Hysterectomy Form meets the requirements.

If the woman was sterile prior to the hysterectomy, the recipient must sign the Acknowledgment of Information for Hysterectomy Form. Alternately, the physician may write a statement that the recipient was sterile prior to the hysterectomy and the reason for the sterility. The statement must be signed and dated by the physician and the statement must be attached to the claim.

When a recipient requires a hysterectomy due to a life threatening emergency, and the physician determines that prior acknowledgment is not possible, the physician must certify in writing that the hysterectomy was performed under a life-threatening emergency in which he or she determined prior acknowledgment was not possible. The physician must also include a description of the nature of the emergency. This statement, signed and dated by the physician, must be attached to the claim.

This service does not need to be prior authorized by the department.

IMPLANTED NERVE STIMULATORS

The implantation of a central nervous system stimulator may be covered by South Dakota Medicaid as therapy for relief of chronic non-malignant intractable pain (greater than 6 month's duration) when the following criteria are met:

1. There is documentation in the medical record of failure of 6 months of conservative therapy (pharmacologic, surgical, psychological, physical), if appropriate and not contraindicated;
2. Further surgical intervention is not indicated;
3. A psychological evaluation has been obtained and there is documentation that the pain is not psychological in origin;
4. No contraindications to implantation exist; and
5. A temporary trial of spinal cord stimulation has shown 50% reduction in pain for at least 2 days and there is documented improvement in function.

SACRAL NERVE STIMULATION

With written authorization from South Dakota Medicaid implantable Sacral Nerve Stimulators may be approved for the treatment of urinary voiding dysfunction (urinary urge incontinence, non-obstructive urinary retention, and urinary urgency/frequency syndrome) when the following conditions are met:

1. Patient has not responded to prior behavioral and pharmacological interventions over 6 months of documented treatment;
2. Incontinence is not related to a neurological condition;
3. Symptoms of incontinence have been present for at least 12 months and have resulted in significant disability, such as limited ability to work or participate in activities outside the home; and
4. A test stimulation has demonstrated 50% or greater improvement in incontinence, as documented in voiding diaries submitted for review with the request.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical record documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

LONG TERM ACUTE CARE

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical record documentation to support medical necessity.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

LOW AIR LOSS / PRESSURE REDUCTION THERAPY

Coverage for pressure reduction overlay or mattress, low-air-loss bed therapy, and air-fluidized therapy is subject to the following restrictions:

1. The services must be provided in the recipient's place of residence;
2. Services are limited to three months when prescribed by a physician for the active healing and treatment of extensive stage III or stage IV pressure sores. The department may grant a one-time, three-month extension if the provider can provide evidence that the wound is healing, but has not completely healed;
3. Services are limited to a maximum of one month when prescribed by a physician for postoperative healing of skin grafts and flap closures;
4. A low-air-loss bed or an air-fluidized system is limited to one which does not have a built-in scale;
5. Services must include weekly wound care consultation by the provider with consultation available 24 hours a day;
6. The provider must have prior written authorization from the department as provided under ARSD §67:16:29:02.02; and
7. The provider must submit monthly documentation as provided under ARSD §67:16:29:02.03 showing progress of the healing of the wound.

Prevention of pressure sores and pain control are not covered under this section.

When requesting prior authorization, the provider must submit the following documentation to the department:

1. The physician's order prescribing the therapy, including the length of therapy;
2. A history of the skin breakdown, including methods of prevention and other treatment used prior to consideration of pressure reduction or low-air-loss bed therapy and the recipient's response to those methods or treatments;
3. The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and
4. Pictures of the pressure sore.

Monthly documentation required under section (7) above must include the following:

1. Physician's documentation outlining the patient's progress and the specific medical reasons for the continued need for pressure reduction therapy. Progressive wound healing must be documented for continued approval;
2. The patient's status, including a description of the wound, its site, stage, size, depth, and drainage; wound treatments; general medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status; mobility status; and amount of time off the therapy and ability to ambulate and reposition; and
3. Pictures showing the wound healing process.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Physician's prescription
- Medical Records including:
  - Diagnosis;
  - Previous treatments attempted and results Or documentation of why more conservative treatments have not been attempted;
  - Anticipated length of treatment;
  - Description of the wound, its site, stage, size, depth, and drainage; wound treatments;
  - General medical status and coexisting medical conditions; nutritional status and dietary consultation; recommended calorie intake with a summary of percent consumed; fluid intake; hydration; skin turgor; continence status;
  - Mobility status including amount of time off the therapy and ability to ambulate and reposition; and
  - Pictures of the pressure sore.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

LYMPHEDEMA PUMPS

Coverage of lymphedema pumps is subject to the following restrictions:

1. The pump must be provided in the recipient's residence;
2. All other first-line treatments, such as salt restriction and wrapping, have failed; and
3. The provider must have received prior written authorization from the department

Before the department authorizes a lymphedema pump, the provider must provide documentation to the department which substantiates the medical necessity of the pump. Medical documentation must include the diagnosis, the first line medical treatment attempted, and the anticipated length of treatment.

If the segmental pump is being required, documentation must substantiate the medical contraindication for the nonsegmental pump.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Physician's prescription
- Medical Records including:
  - Diagnosis
  - Previous treatments attempted and results Or documentation of why more conservative treatments have not been attempted
  - Anticipated length of treatment
  - If a segmental pump is being prescribed, documentation must substantiate the contraindication of the non-segmental pump

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

MEDICALLY COMPLEX / REHAB FOR CHILDREN

The Prior Authorization Request Form is to be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions

ADMISSION REQUIREMENTS

Admission to a medically complex program is a covered service if the following criteria are met:

1. Medical documentation substantiates that the service is medically necessary. Medical documentation includes a diagnosis, a complete medical history, copies of progress notes from physicians or other professionals providing care or services, laboratory tests, X rays, physician orders and a treatment plan outlining the needed care, and any other documentation which may be necessary to determine medical necessity for the child's admission;
2. Home health care is not a viable option as determined by the department based on the child's medical needs, the availability of home health services, and cost effectiveness;
3. The facility has notified the child's school district that the child has been referred to the facility for services and may be in need of an educational program;
4. The cost of care does not exceed the cost of care in the child's home; and
5. Professional nursing services are necessary on a 24-hour basis and the child requires at least two of the following services:
    - Intravenous medications more than twice a day which must be administered by a registered nurse;
    - Drug therapy stabilization which requires skilled monitoring on a 24-hour basis;
    - Nutritional therapy during an unstable period;
    - Alternative nutritional feeding, such as nasogastric or gastrostomy feeding, during an unstable period;
    - Tracheostomy care during an unstable period;
    - Colostomy or ileostomy care during an unstable period;
    - Skilled skin care and monitoring for the treatment of a decubitus ulcer;

- Monitoring of oxygen saturation when oxygen is being administered;
- Skilled nursing observation and assessment following casting or surgeries;
- Direct paraprofessional care for more than eight hours a day which is supervised by a medical professional;
- Peritoneal dialysis during an unstable period;
- Infectious disease care during an unstable period;
- Use of a ventilator during an unstable period; or
- Professional monitoring to manage end stage disease process.

For purposes of this section, an unstable period is that period of time necessary for a child to return to a medically stable state following a disease process, illness, or surgery.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical record documentation to support the above requirements

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

MENTAL HEALTH VISITS BEYOND THE COVERAGE LIMIT

A mental health provider must have prior authorization from the department before providing any service listed in ARSD § 67:16:41:09 which will exceed the limits established by the department. Authorization is based on documentation submitted to the department by the mental health provider. The documentation must include the provider's written treatment plan, the diagnosis, and the planned treatment. Failure to obtain approval from the department before providing the service is cause for the department to determine that the service is a non-covered service.

The department may verbally authorize services; however, the department must verify a verbal authorization in writing before the services are paid. Services which exceed the established limits are subject to peer reviews according to ARSD § 67:16:41:15. Services must meet all the requirements of ARSD Chapter 67:16:41.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Applicable Medical Records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

MENTAL HEALTH VISITS FOR CHILDREN UNDER 2 YEARS OF AGE

This is the procedure for community mental health centers funded through the Department of Social Services (HCPC code H2021)

DOCUMENTATION REQUIREMENTS

- Child's name
- Child's Date of Birth
- SD Medicaid ID # (if eligible)
- A description of the presenting problems
- Diagnosis or diagnostic impression
- Planned course of treatment

*Any services provided prior to the waiver approval will not be covered services.

Submit completed documentation to:

Department of Social Services
Division of Behavioral Health
700 Governors Drive.
Pierre, SD 57501
Phone: (605) 773-3123
Fax: (605) 773-7076

NEGATIVE PRESSURE WOUND THERAPY PUMPS V.A.C.

The Prior Authorization Request Form and The Certificate of Medical Necessity for Durable Medical Equipment (DME) is to be completed by the prescribing physician for all types of covered durable equipment ordered for Medicaid eligible recipients. This form is to be used by DME suppliers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

These forms is to be used by nutritional therapy suppliers (DME, physician or pharmacy) as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to Medicaid for payment.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Physician's prescription
- Applicable medical records or evaluation to meet above requirements.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

NEONATAL INTENSIVE CARE UNIT

All stays must be prior authorized by the Department of Social Services. Please send the admissions H and P (History and Physical) within one business day of completion and weekly progress reports.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: NICU Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

Please label fax coversheets as NICU updates and indicate the facility name

NUTRITION THERAPY

PARENTERAL NUTRITION AND ENTERAL NUTRITION FOR ADULTS OVER 20 YEARS OLD

The Prior Authorization Request Form which includes the Certificate of Medical Necessity for Nutritional Therapy must be completed by the prescribing physician for all types of covered nutritional therapy ordered for Medicaid-eligible recipients.

Nutritional therapy suppliers (DME, physician or pharmacy) are to provide written documentation to support medical necessity and must complete the forms maintained in the patient's medical record prior to submitting a claim to Medicaid for payment.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

The service must be provided according to the requirements contained in ARSD Chapter 67:16:42: Nutritional Therapy and Nutritional Supplements:

- 67:16:42:01 Definitions.
- 67:16:42:02 Enteral nutritional therapy and nutritional supplements for individual under 21 years of age.
- 67:16:42:03 Enteral nutritional therapy for individual 21 years of age and older.
- 67:16:42:04 Enteral nutritional therapy for individual 21 years of age and older -- Prior authorization required.
- 67:16:42:05 Parenteral nutritional therapy.
- 67:16:42:06 Parenteral nutritional therapy -- Prior authorization required.
- 67:16:42:07 Nutritional therapy and nutritional supplements -- Limits.
- 67:16:42:08 Services not covered.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Physician's prescription

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

OUT-OF-STATE SERVICES

INPATIENT SERVICES

Effective January 13, 2014 South Dakota Medicaid implemented a Prior Authorization requirement on all inpatient hospitalizations more than 50 miles outside of the state of South Dakota, except Bismarck, North Dakota.

OUTPATIENT SERVICES

Effective September 1, 2014 South Dakota Medicaid will expand the Out-of-State Prior Authorization requirement to most medical services received more than 50 miles outside of the state of South Dakota, except Bismarck, North Dakota. This applies to all Medicaid recipients, except those in foster care.

Prior Authorization by South Dakota Medicaid does not guarantee payment. The provider must be an enrolled South Dakota Medicaid provider and must submit a timely and accurate claim. Also, the recipient must be eligible for coverage on the date of service.

Out-of-state providers not currently enrolled in South Dakota Medicaid must obtain prior authorization and provide the service before provider enrollment can be completed. See FAQs for additional information.

DOCUMENTATION REQUIREMENTS

- Out-of-State Prior Authorization Request Form
- All applicable medical records to support provision of services out-of-state.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

PANNICULECTOMY

Written prior authorization will be required from South Dakota Medicaid. This procedure will not be covered for cosmetic purposes. In order for prior authorization to be granted the procedure must be considered medically necessary and the following criteria must be met:

- The recipient is 21 years or older;
- The pannus causes a continuous or frequently recurrent skin condition, such as intertrigo, cellulitis, or skin necrosis not responsive to documented good hygiene practices and conservative medical therapy of at least 6 months duration;
- The panniculus hangs below the symphysis with photographic documentation submitted;
- The pannus significantly interferes with activities of daily living; and
- If the surgery is considered after significant non-surgical weight loss there must be documentation of stable weight for 6 months or if the weight loss occurs after bariatric surgery panniculectomy will not be considered until at least 18 months after the bariatric procedure and documentation of stable weight for at least the last 6 months.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Surgical Evaluation
- Applicable medical records describing problems related to pannus and conservative treatments tried.
- Pictures of the pannus.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

Please review ARSD Chapter 67:16:47 for all rules applicable to PRTFs.

Treatment at an eligible facility is a covered service if the following conditions are met:

1. The individual is under the age of 21 or, if treatment began before the individual reached the age of 21, the treatment may continue until the date it is no longer needed or the date the individual reaches the age of 22, whichever occurs earlier;
2. The state review team has determined that the conditions of § 67:16:47:04.02 have been met;
3. The certification team has certified that the requirements contained in § 67:16:47:04.04 have been met;
4. The services are expected to improve the individual's emotional and behavioral condition or prevent further regression; and
5. The individual is eligible for medical assistance under article 67:46.

The referring source shall gather and supply to the department the documentation necessary to determine eligibility.

Before an individual may be admitted to a facility for treatment, the department's certification team must approve the individual's admission to the facility. Approval is based on a review of the following documentation:

1. The individual's social history that includes past and current behaviors that have prompted the request for admission to a residential facility;
2. A psychological evaluation and diagnosis that was completed within the past 12 months; if available
3. A summary of the individual's behaviors during school from the individual's school district, if available;
4. Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;
5. A summary of outpatient care services that have been provided, including outcomes and recommendations; and
6. An alcohol and drug screening assessment, if available.

The placing agency shall gather and supply to the department the required documentation.

For emergency admissions, the certification team shall complete its review on the first working day following the date of admission into the residential treatment center.

DOCUMENTATION REQUIREMENTS

- South Dakota PRTF Referral Form
- The individual's social history that includes past and current behaviors that have prompted the request for admission to a residential facility;
- A psychological evaluation and diagnosis that was completed within the past 12 months, if available;
- A summary of the individual's behaviors during school from the individual's school district, if available;
- Copies of the discharge summaries from previous acute inpatient psychiatric hospitalizations, if applicable;
- A summary of outpatient care services that have been provided, including outcomes and recommendations; and
- An alcohol and drug screening assessment, if available.

Submit completed documentation to:

Department of Social Services
ATTN: Auxiliary Placement
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3448
Fax: 605-773-7183

REQUIREMENTS FOR CONTINUED STAY IN RESIDENTIAL TREATMENT FACILITIES

Please review ARSD Chapter 67:16:47 for all rules applicable to PRTFs.

An individual's continuous and uninterrupted stay in a facility is a covered service if the certification team determines, based on the child's progress report required by ARSD §§ 67:42:08:07 or 67:42:15:11, that all of the following conditions are met:

1. The individual is actively participating in the treatment;
2. The individual continues to require the authorized level of care and is not able to function or use outpatient care as reflected in the physician's, nurse's, or auxiliary staff's notes;
3. The individual is complying with the recommendations made by the treatment team; and
4. The individual's daily progress notes show improvement towards the goal of discharge.

DOCUMENTATION REQUIREMENTS FOR CONTINUED STAY

- South Dakota PRTF Continued Stay Form
- All other applicable records to substantiate the requirements above

Submit completed documentation to:

South Dakota Foundation for Medical Care
2600 West 49th Street
Sioux Falls, SD 57105
Fax: 605-773-0580
Phone: 605-336-3505

QUESTIONABLY COSMETIC PROCEDURES

The Prior Authorization Request Form must be completed by the prescribing physician for all covered services requiring prior authorization for Medicaid eligible recipients.

This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid. This form is to be used by providers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical record documentation to support the above requirements
- Pictures

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

REMOVAL OF EXCESS SKIN

To be medically necessary, the covered service must meet the following conditions:

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

In addition to items and services specified as not covered in other sections of this article, the following are examples of items and services not covered by South Dakota Medicaid:

- Cosmetic surgery to improve the appearance of an individual when not incidental to prompt repair following an accidental injury or any cosmetic surgery which goes beyond that which is necessary for the improvement of the functioning of a malformed body member.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Surgical Evaluation
- Applicable medical records describing problems related to excessive skin and conservative treatments tried.
- Pictures of the excessive skin.

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

SKILLED HOME CARE SERVICES / PRIVATE DUTY NURSING

South Dakota Medicaid covers medically necessary Skilled Home Care and extended home health aide services for children under 21 years old when a prior authorization has been obtained. These services may be performed by an enrolled private duty nursing agency pursuant to the plan of care developed in collaboration with the primary care provider. The intent is to allow/maintain the care of individuals in their place of residence, as long as it is safe to do so. To be medically necessary, the covered service must meet the following conditions (ARSD 67:16:01:06.02):

- It is consistent with the recipient's symptoms, diagnosis, condition, or injury;
- It is recognized as the prevailing standard and is consistent with generally accepted professional medical standards of the provider's peer group;
- It is provided in response to a life-threatening condition; to treat pain, injury, illness, or infection; to treat a condition that could result in physical or mental disability; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition;
- It is not furnished primarily for the convenience of the recipient or the provider; and
- There is no other equally effective course of treatment available or suitable for the recipient requesting the service which is more conservative or substantially less costly.

Criteria in ARSD under Private duty nursing and EPSDT must also be met:

DOCUMENTATION REQUIREMENTS

- Private Duty Nursing & Extended Home Health Services Prior Authorization Request Form
- Medical record documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

SPEECH GENERATING DEVICE

The Prior Authorization Request Form which includes the Certificate of Medical Necessity for Durable Medical Equipment (DME) is to be completed by the prescribing physician for all types of covered durable equipment ordered for Medicaid eligible recipients. This form is to be used by DME suppliers as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to South Dakota Medicaid.

These forms is to be used by nutritional therapy suppliers (DME, physician or pharmacy) as written documentation to support medical necessity and must be completed and maintained in the patient's medical record prior to submitting a claim to Medicaid for payment.

To be medically necessary, the covered service must meet the conditions of ARSD §67:16:29:02:

- 67:16:29:02.07 Augmentative communication device -- Modification -- Prior authorization -- Required documentation.
- 67:16:29:02.08 Requirements for supervising speech pathologist.
- 67:16:29:02.09 Augmentative communication device -- Assessment requirements.
- 67:16:29:02.10 Augmentative communication device -- Maintenance and repair.
- 67:16:29:02.11 Augmentative communication device -- Purchase of warranty.

DOCUMENTATION REQUIREMENTS

- DME and Nutrition Prior Authorization Request Form
- Evaluation by a speech pathologist meeting requirements of ARSD

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

SPINAL SURGERY

South Dakota Medicaid **requires** prior authorization for all elective spinal surgeries. Surgeries involving acute traumatic injury, surgical treatment for malignant disease of the spine or primary infections of the spine **do not require** prior authorization.

Approval will be considered after review of documentation of the following:

1. Abnormal physical findings and/or functional limitations recorded in the medical record;
2. Reports of all diagnostic procedures done in the course of evaluation; and
3. Response to conservative management over 3 months including any physical therapy, exercise programs, activity modification, and/or injections in the absence of progressive neurological symptoms.
4. If the recipient is a tobacco user, tobacco use must be discontinued for 3 months prior to the surgery with documentation in the medical record.

Some **examples** of the codes for procedures that require prior authorization in the above circumstances are:

22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22840-49, 22851-65, 22899, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042-49, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075-78, 63180, 63182, 63185, 63190, 63191, 63194-99, 63200

This is not considered an exclusive list and codes may change as new procedures become available or CPT codes are modified.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical record documentation

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

STERILIZATION

South Dakota Medicaid will deny payment to physicians, hospitals, surgical-clinics, anesthesiologists, anesthetists, or any provider billing for services involving sterilization unless the Consent Form for Sterilization is completed and submitted with the claim.

The Sterilization Consent Form must be accurately completed and attached to the claim.

Instructions for completing the form are as follows:

- Provide a copy of the consent form to the individual to be sterilized.
- Offer to answer any questions the individual has about sterilization.
- Give the following information to the person to be sterilized:

1. That they may withdraw their consent at any time prior to sterilization and that the withdrawal will not affect any program benefits.
2. A description of alternative methods of birth control.
3. The procedure is considered to be irreversible.
4. An explanation of the sterilization procedure to be performed.
5. An explanation of discomforts and risks of the sterilization procedure, including anesthetic risks.
6. A full description of the benefits that may be expected.
7. An explanation that the sterilization cannot be performed for at least 30 days except for circumstances listed under “Exceptions”.

Arrangements will be made to effectively inform the blind, deaf and those who do not understand the language.

The informed consent for sterilization is not to be obtained while the individual is:

- In labor or child birth.
- Seeking to obtain or obtaining an abortion.
- Under the influence of alcohol or drugs.

In the event of a premature delivery, the following must occur:

- The consent form must be signed by the individual to be sterilized at least 30 days prior to expected delivery date and at least 72 hours prior to the sterilization.
- The date of the expected delivery must be written on the consent form.

In the event a sterilization is performed during an emergency abdominal surgery, the following must occur:

- The consent form must be signed by the individual to be sterilized at least 72 hours prior to sterilization.
- The physician must describe the surgery and explain the medical necessity of the emergency abdominal surgery.
- **A sterilization is not consider an emergency.**

This service does not require prior authorization from the department.

SYNAGIS/RESPIGAM

Synagis and Respigam are covered by South Dakota Medicaid starting November 1st of each calendar year through March 31st of the following calendar year when a child meets all of the following criteria:

- The medication has been prior authorized by the Department of Social Services/Medicaid
- The medication has been recommended by a Neonatologist, Pediatric Pulmonologist, or Pediatric Cardiologist; and
- The child meets one of the following categories listed below:
  1. Children under 6 months of age at the onset of the RSV season who were 32 weeks and less gestational age at birth.
  2. Children under 3 months of age at the onset of the RSV season or who are born during the RSV season (11/1-3/31/) who were between 32 and 35 weeks gestational age at birth with one of these 2 risk factors: day care attendance or a sibling in the household less than 5 years of age.
  3. Children under two years of age at the onset of the RSV season with evidence of ongoing lung disease such as bronchopulmonary dysplasia or cystic fibrosis requiring treatment with oral bronchodilators, supplemental oxygen, diuretics, or nebulized or inhaled medications to stabilize the disease in the last 6 months.
  4. Children under two years of age at the onset of the RSV season with evidence of hemodynamically significant cyanotic or acyanotic congenital heart disease and one of the following: receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, or undergoing surgical procedures that use cardiopulmonary bypass.
  5. Children under two years of age at the onset of the RSV season with immunodeficiencies that may make them more susceptible to severe lower respiratory tract disease related to RSV.
  6. Any child under two years of age at the onset of the RSV season felt to be at high risk for significant lower respiratory tract illness related to RSV.

REQUIRED DOCUMENTATION

- Synagis Prior Authorization Request Form

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246

TRANSPLANTS

HEART TRANSPLANT

An individual may be eligible for a heart transplant if the individual meets the following criteria and written prior authorization has been obtained from South Dakota Medicaid:

1. The individual must have a critical medical need with a life expectancy of less than one year without a transplant;
2. The individual must have tried or considered all other medical and surgical therapies that might be expected to yield both short- and long-term survival;
3. The individual must be free of all strongly adverse factors, such as severe pulmonary hypertension; renal or hepatic dysfunction not explained by the underlying heart failure and not considered reversible; acute severe hemodynamic compromise at the time of transplantation if accompanied by compromise or failure of one or more vital end-organs; symptomatic peripheral vascular or cerebrovascular disease; chronic obstructive pulmonary disease or chronic bronchitis; active systemic infection; recent and unresolved pulmonary infarction, pulmonary roentgenographic evidence of infection or abnormalities of unclear etiology; uncontrolled systemic hypertension, either at transplantation or prior to development of end-stage heart disease; cachexia, even in the absence of major end-organ failure; a history of a behavior pattern considered likely to interfere significantly with compliance with a disciplined medical regimen; or any other systemic disease considered likely to limit or preclude survival and rehabilitation after transplantation;
4. The individual must be free of other factors less adverse but considered importantly adverse such as insulin-requiring diabetes mellitus with associated vascular complications of kidney or retina, severe neuropathy; or asymptomatic severe peripheral or cerebrovascular disease;
5. The plans for long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient; and
6. The procedure will be performed at a Medicare-approved transplant center.

LIVER TRANSPLANT

An individual may be eligible for a liver transplant if the individual meets the following criteria and written prior authorization has been obtained from South Dakota Medicaid:

1. The individual must have a critical medical need with less than 24 months of expected survival;
2. The individual must be free of all strongly adverse factors such as irreversible brain damage; multi-system failure not correctable by transplant; malignancy outside of the liver (excluding skin cancer); alcohol or other substance abuse not in remission for at least 6 months; advanced cardiopulmonary disease; active systemic infection; other significant co-morbidities; or history of a behavior

pattern considered likely to interfere significantly with compliance to a disciplined medical regimen;
3. The plans for long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient; and
4. The procedure will be performed at a Medicare-approved transplant center.

OTHER TRANSPLANTS

Kidney and Cornea transplants are a covered service and do not require a prior authorization. All other transplant types may be covered only when a prior authorization has been obtained. Services must be medically necessary and not experimental.

Services must meet the requirements of ARSD Chapter 67:16:31.

DOCUMENTATION REQUIREMENTS

- General Prior Authorization Request Form
- Medical Records

Submit completed documentation to:

Department of Social Services
Division of Medical Services
ATTN: Nurse Consultant
700 Governors Drive
Pierre, SD 57501
Phone: 605-773-3495
Fax: 605-773-5246